

Massachusetts Department of Public Health Office of Emergency Medical Services Part D: Place of Business



Please fill out a separate form for each headquarters, each garage location or place of business where you maintain ambulances (Make as many copies of this form as needed).

1) Service Number 2) Ambulance Service Name						
3) PLACE OF BUSINESS						
Address						
City			State		Zip	
Business Phone Number [For this location] Emergency Phone Number (non 911)						
4) Is this location your headquarters? YES NO Fax Phone Number ())
5) Number of vehicles normally operated at this location						
Class I	Class II	Class IV	Class V			
6) Is service from this place of business provided 24 hours a day, 7 days a week? If no, please explain: 7) What type of service(s) is						
being provided from this Basic						
(Check all that apply) ALS-Paramedic						
8) How many hours per day is ALS-Intermediate service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
9) How many hours per day is ALS-Paramedic service available? (if applicable)						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
10) ALS Informa	-	1	1		1	1 -0.
Mass Controlled Substance Registration # Expiration Schedule						
Hospital with which you have an Affiliation Agreement						

OEMS Form 500-1 (11/02)